Advantage by Bridgeway Health Solutions, H5590
Dual Eligible Dual Subset Special Needs Plan

Model of Care Score: 88.75%
Three Year Approval **January 1, 2013 – December 31, 2015**

Target Population

Bridgeway enrolls beneficiaries that are full benefit dual-eligible and Qualified Medicare Beneficiaries (QMB) and has a contract with the State of Arizona to provide Medicaid benefits to those who are eligible for that program. The characteristics of the population often include one or more of the following: low income, reluctance to seek preventative services, co-morbidities, behavioral health/substance abuse issues, and communication/language issues.

Provider Network

Bridgeway provides enrollees access to a wide range of credentialed and contracted providers that include: physicians; nurse practitioners; physician assistants; dietitians; acute care facilities such as hospitals, emergency departments, urgent care centers and some long-term care hospitals. They also have the following providers: laboratories; skilled nursing facilities; federally qualified healthcare centers (FQHCs); rural healthcare centers (RHCs); pharmacies, radiography facilities; rehabilitative facilities; dialysis centers; outpatient surgery centers; hospices; home health agencies; infusion centers; durable medical equipment suppliers; behavioral health practitioners; oral/dental specialists and vision specialists.

Care Management and Coordination

The health risk assessment (HRA), a standardized assessment tool created by Bridgeway, is designed to identify the needs of the most vulnerable members by evaluating medical, psychological, functional and cognitive needs. HRAs are conducted by Bridgeway care managers within 90 days of the member's enrollment, usually by phone. In-person assessments are done when warranted. Assessments are then conducted annually or more frequently if needed based on the members' health status. Bridgeway uses the results of the HRA, claims data and a predictive modeling tool to stratify each member into low, medium or high priority risk status. The risk status determines the specific areas of focus for the member and the frequency of contact and intensity of interventions and assignment to care coordination, care management or complex care management.

The assessment is conducted primarily by phone or in person by a case manager, who presents the results of the assessment to the interdisciplinary team (ICT) to compose an individualized

care plan (ICP) that focuses on attainable goals and oversight. The ICT works with the enrollee (or enrollee's designated representative), the member's primary care physician (PCP), and other key specialists when feasible to develop an ICP specific to the needs of the individual and designed to mitigate any identified risks. The ICP includes a set of attainable goals and measurable outcomes including, preventive health services delivered to the enrollee, preferences for care, chronic conditions and special needs of the enrollee. The care included in the ICP is intended to increase self-management, improve mobility and functional status, reduce any pain and create an improved satisfaction with health status and health care services that result in improved quality of life perception. The ICT communicates any changes in the ICP to the beneficiary, other members of the ICT, and providers as needed via email, mail, and fax and documents this in a clinical documentation system.

The interdisciplinary care team (ICT) is generally comprised of multidisciplinary employed clinical and nonclinical staff. The non-medical personnel perform non-clinical based health service coordination and clerical functions, and licensed professional staff focus on the more complex and clinically based service coordination needs. The ICT, overseen by the medical director also includes a case manager, behavioral health coordinator, program coordinator, pharmacist, and member connections representative. In addition, the ICT also includes a primary care provider and specialty care providers pertinent to the member's needs such as, a nurse practitioner, mid-level provider, social worker, registered nurse, occupational/speech/physical therapist, dietician, pharmacist, health educator, disease manager, behavioral/mental health specialist, community resources specialist, dentist, pastoral services, or others.

This MOC summary is intended to provide a broad overview of the SNP's MOC. Although the full extent of any MOC cannot be conveyed in a short summary, this summary provides the reader with a general overview of how the SNP addresses beneficiary needs.

For more information about this health plan refer to the Special Needs Plan's website at:

http://advantage.bridgewayhs.com/